Name: DOB:	Name: DOB:	Name: DOB:
TST: mm induration Date Read:	TST: mm induration Date Read:	TST: mm induration Date Read:
IGRA: □ Pos □ Neg Date:	IGRA: □ Pos □ Neg □ Date: □	IGRA: □ Pos □ Neg Date:
Chest X-Ray: Date:		Chest X-Ray: Date: □ Normal □ Abnormal (Stable)
Treatment Completed: ☐ Yes ☐ No (Contact Provider)	Treatment Completed: ☐ Yes ☐ No (Contact Provider)	Treatment Completed: ☐ Yes ☐ No (Contact Provider)
Name of Drug(s):	Name of Drug(s):	Name of Drug(s):
Started: Stopped: # Mos:	Started: Stopped: # Mos:	Started: Stopped: # Mos:
Provider Name:	Provider Name:	Provider Name:
Signature: Phone: ()	Signature: Phone: ()	Signature: Phone: ()
Name: DOB:	Name: DOB:	Name: DOB:
TST: mm induration Date Read:	TST: mm induration Date Read:	TST: mm induration Date Read:
IGRA: ☐ Pos ☐ Neg Date:	IGRA: ☐ Pos ☐ Neg Date:	IGRA: □ Pos □ Neg Date:
Chest X-Ray: Date: □ Normal □ Abnormal (Sta	le) Chest X-Ray: Date:	Chest X-Ray: Date: □ Normal □ Abnormal (Stable)
Treatment Completed: ☐ Yes ☐ No (Contact Provider)	Treatment Completed: ☐ Yes ☐ No (Contact Provider)	Treatment Completed: ☐ Yes ☐ No (Contact Provider)
Name of Drug(s):	Name of Drug(s):	Name of Drug(s):
Started: Stopped: # Mos:	Started: Stopped: # Mos:	Started: Stopped: # Mos:
Provider Name:	Provider Name:	Provider Name:
Signature: Phone: ()	Signature: Phone: ()	Signature: Phone: ()
Name: DOB:	Name: DOB:	Name: DOB:
TST: mm induration Date Read:	TST: mm induration Date Read:	TST: mm induration Date Read:
IGRA: □ Pos □ Neg Date:	IGRA: □ Pos □ Neg Date:	IGRA: □ Pos □ Neg Date:
Chest X-Ray: Date: Normal		Chest X-Ray: Date:
Treatment Completed: ☐ Yes ☐ No (Contact Provider)	Treatment Completed: ☐ Yes ☐ No (Contact Provider)	Treatment Completed: ☐ Yes ☐ No (Contact Provider)
Name of Drug(s):	Name of Drug(s):	Name of Drug(s):
	**************************************	**************************************
Started: Stopped: # Mos: Provider Name:	Started: Stopped: # Mos: Provider Name:	Started: Stopped: # Mos: Provider Name:
Signature: Phone: ()	Signature: Phone: ()	Signature: Phone: ()

Your TB Test and Treatment Record	Your TB Test and Treatment Record	Your TB Test and Treatment Record
Show this card to your doctor. Report the following symptoms if they last more than 2 weeks:	Show this card to your doctor. Report the following symptoms if they last more than 2 weeks:	Show this card to your doctor. Report the following symptoms if they last more than 2 weeks:
Cough Shortness of breath Chest pain	Cough Shortness of breath Chest pain	Cough Shortness of breath Chest pain
Coughing up blood Feeling weak or tired night sweats	Coughing up blood Feeling weak or tired night sweats	Coughing up blood Feeling weak or tired night sweats
Fever and chills Losing weight without trying	Fever and chills Losing weight without trying	Fever and chills Losing weight without trying
Your TB Test and Treatment Record	Your TB Test and Treatment Record	Your TB Test and Treatment Record
Show this card to your doctor. Report the following symptoms if they last more than 2 weeks:	Show this card to your doctor. Report the following symptoms if they last more than 2 weeks:	Show this card to your doctor. Report the following symptoms if they last more than 2 weeks:
Cough Shortness of breath Chest pain	Cough Shortness of breath Chest pain	Cough Shortness of breath Chest pain
Coughing up blood Feeling weak or tired night sweats	Coughing up blood Feeling weak or tired night sweats	Coughing up blood Feeling weak or tired night sweats
Fever and chills Losing weight without trying	Fever and chills Losing weight without trying	Fever and chills Losing weight without trying
Your TB Test and Treatment Record	Your TB Test and Treatment Record	Your TB Test and Treatment Record
Show this card to your doctor. Report the following	Show this card to your doctor. Report the following	Show this card to your doctor. Rreport the following
Show this card to your doctor. Report the following	Show this card to your doctor. Report the following	Show this card to your doctor. Rreport the following
Show this card to your doctor. Report the following symptoms if they last more than 2 weeks:	Show this card to your doctor. Report the following symptoms if they last more than 2 weeks:	Show this card to your doctor. Rreport the following symptoms if they last more than 2 weeks: